CLINICAL PRIVILEGES – DERMATOLOGIST

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.
PRINCIPAL PURPOSE: To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.
ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

INSTRUCTIONS

APPLICANT: In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect current capability and should not consider any known facility limitations. Sign and date the form. Forward the form to your Clinical Supervisor. *(Make all entries in ink.)*

CLINICAL SUPERVISOR: In Part I, using the facility master privileges list, enter Code 1, 2, 3, or 4 in each VERIFIED block in answer to each requested privilege. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form. Forward the form to the Credentials Function. *(Make all entries in ink.)*

CODES:
1. **Fully competent within defined scope of practice.** ***(Clinical oversight of some allied health providers is required as defined in AFI 44-119.)***
2. **Supervision required.** ***(Unlicensed/uncertified or lacks current relevant clinical experience.)***
3. **Not approved due to lack of facility support.** ***(Reference facility master privileges list.)***
4. **Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.**

CHANGES: Any change to a verified/approved privileges list must be made in accordance with AFI 44-119.

NAME OF APPLICANT *(Last, First, Middle Initial)*	NAME OF MEDICAL FACILITY

I. LIST OF CLINICAL PRIVILEGES – DERMATOLOGIST

Requested	Verified		Requested	Verified	
		A. LABORATORY STUDIES			**C. SPECIAL PROCEDURES (continued)**
		1. Darkfield examinations			**2. Grenz ray therapy**
		2. Fungal cultures			**3. Chemotherapy for psoriasis**
		3. Potassium hydroxide (KOH) preps; Wright's *(Tzanck)* and Gram's stains			**4. Sclerotherapy**
		4. Skin/patch tests for delayed hypersensitivity			**5. Chemotherapy of serious or life-threatening dermatologic disease**
					6. Conscious sedation privileges
		B. SURGICAL PROCEDURES			**7. Operating room privileges**
		1. Skin biopsies			**D. LASER SURGERY *(Provider may specify individual laser systems)***
		2. Excision of benign and malignant lesions			**1. Laser resurfacing *(Specify)***
		3. Electrosurgical removal of benign and malignant lesions			**a.**
					b.
		4. Cryosurgical removal of benign and malignant lesions			**2. Treatment of pigmented lesions *(Specify)***
					a.
		5. Mohs micrographic removal of benign and malignant lesions			**b.**
					3. Treatment of cutaneous vascular lesions *(Specify)*
		6. Incision and drainage of small cysts and abscesses			**a.**
					b.
		7. Acne surgery			**4. Laser for hair removal *(Specify)***
		8. Surgery of the nail unit			**a.**
		9. Dermabrasion			**b.**
		10. Chemical peels			**5. Laser treatment of cutaneous vascular lesions, tattoos, warts, and other cutaneous disease *(Specify)***
		11. Hair transplantation			
		12. Tumescent liposuction			**a.**
		13. Blepharoplasty			**b.**
		14. Sclerotherapy of venous telangiectasia			**E. OTHER *(Specify)***
		15. Collagen injection			**1.**
		C. SPECIAL PROCEDURES			**2.**
		1. Phototherapy/photochemotherapy			**3.**

SIGNATURE OF APPLICANT	DATE

CLINICAL PRIVILEGES – DERMATOLOGIST *(Continued)*

II. CLINICAL SUPERVISOR'S RECOMMENDATION

☐ **RECOMMEND APPROVAL**

☐ **RECOMMEND APPROVAL WITH MODIFICATION** *(Specify below)*

☐ **RECOMMEND DISAPPROVAL** *(Specify below)*

SIGNATURE OF CLINICAL SUPERVISOR (Include typed, printed, or stamped signature block)	**DATE**